

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a film 402 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05697 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05700

1. DECEASED-NAME (Type or Print)		First AVERY	Middle NEWTON	Last AYRES, III		2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 4/30/68 19		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH Jan. 6, 1952		6. AGE (In years last birthday) 16 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month April 30, Day Year 1968	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route #3		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY School		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route #3, B-47 Wright's Trailer Village
14. FATHER'S NAME First Avery Middle Newton Last Ayers Jr.		15. MOTHER'S MAIDEN NAME First Lucille Middle Simmons Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Father, Same as 10-&11				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause of death undetermined at autopsy 7969 DUE TO, OR AS A CONSEQUENCE OF and by Chemical analyses. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7955								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/30/68		
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2 May 68		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Aberdeen, Harford- Md.		
24. FUNERAL DIRECTOR Webster W. W. W. Co.		ADDRESS Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE MAY 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

72320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1-7-68

05693										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05701																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last Anne Elizabeth Battista										Month Day Year April 1 1968										1:26 M																													
3. SEX Female										4. RACE white										5. DATE OF BIRTH June 14, 1915										6. AGE (In years last birthday) 52 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Bridgeport, Conn.										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH HARFORD Md.																			
10. CITY OR TOWN OF DEATH HARFORD										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk										12b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY HARFORD										13c. CITY OR TOWN Joppa										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 2617 Green Spring Ave									
14. FATHER'S NAME First Middle Last Unknown										15. MOTHER'S MAIDEN NAME First Middle Last Unknown										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no										16b. SOCIAL SECURITY NO. 040-09-8899										17. INFORMANT Frank J. Battista, 2617 Green Spring Ave., Address Joppa, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V. D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hours										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1968, to March 31, 1968, that (I) (we) last saw the deceased alive on March 31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE John D. Yuen										22c. DATE SIGNED 4/1/68																													
22d. PHYSICIAN'S NAME (Type) JOHN D. YUEN										22e. ADDRESS HAURE DE GRACE MD																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Apr. 4, 1968										23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens										23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md																			
24. FUNERAL DIRECTOR Howard K. McConas & Son, Abingdon, Md.										25a. REC'D BY REGISTRAR DATE APR 2 1968										25b. REGISTRAR'S SIGNATURE John Charles J...																													

10701

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05692

05702

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street		c. LENGTH OF STAY IN lb 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN W. BAY				4. DATE OF DEATH Month Day Year April 1, 1968			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1895	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (County & State, or foreign country) Whiteford, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel W. Bay				14. MOTHER'S MAIDEN NAME Mary A. Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-36-8275		17. INFORMANT Address Mrs. John W. Bay, Street, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary sclerosis DUE TO (c) Generalized Ant. Scler. CVD Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201 Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1940 to April 1, 1968 , that (I) (we) last saw the deceased alive on March 31, 1968 , and that death occurred at 11:00 AM , from causes and on the date stated above.							
22a. SIGNATURE Josiah A. Hunt				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Apr. 3, 1968	
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.				22d. ADDRESS Delta, Penna.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 4, 1968	23c. NAME OF CEMETERY OR CREMATORY Highland		23d. LOCATION (City or Town) (County) (State) Street, Harford, Md.			
24. FUNERAL DIRECTOR John H. Harkins				ADDRESS Delta, Penna.		25a. REC'D BY REGISTRAR APR 5 - 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

00720

RECEIVED AT DEPT

00720

[Faint, mostly illegible text and markings covering the page, including what appears to be a large circular stamp or seal in the center.]

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VR 118
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARY Clyde BeBber		2a. DATE OF DEATH Month April Day 15 Year 68		2b. HOUR 12 AM 45	
3. SEX Female		4. RACE White		5. DATE OF BIRTH December 23, 1912	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Harford, GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) HARFORD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Supervisor	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air	
14. FATHER'S NAME First LEE Middle A. Last COMER		15. MOTHER'S MAIDEN NAME First DOANA Middle BIEVINS Last BIEVINS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16b. SOCIAL SECURITY NO. 218-26-3878		17. INFORMANT Husband (838-2784)		Address 11 Elm Street Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4129 DUE TO, OR AS A CONSEQUENCE OF (b) AURICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS. WEEKS YEARS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4330					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/4 , 19 68 , to 4/14 , 19 68 , that (I) (we) last saw the deceased alive on 4/14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles Judge		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-15-68	
22d. PHYSICIAN'S NAME (Type) S. LEYTE-VISAL		22e. ADDRESS 114 W. BEL AIR AVE. ABERDEEN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Welcome Home Baptist Ch. Cem.	
23d. LOCATION (City or Town) Bel Air		23e. (County) Harford Co.		23f. (State) Maryland	
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. BEL Air, Maryland 21014		25a. REC'D BY REGISTRAR APR 17 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

STATE OF NEW YORK

IN SENATE

JANUARY 11, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

JOHN B. LEE, PRINTERS

1901

NEW YORK

STATE OF NEW YORK

IN SENATE

JANUARY 11, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

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1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Harvey Wilson Benjamin			2a. DATE OF DEATH Month Day Year 4 5 - 68			2b. HOUR MIN 4:35 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug 14 - 1885		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Three-de-Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY CECIL		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt #2		
14. FATHER'S NAME First Middle Last William W Benjamin			15. MOTHER'S MAIDEN NAME First Middle Last Josephine Wilson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 187-054673			17. INFORMANT Address Henry Benjamin Rising Sun Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4120</u> <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD + Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fracture hip</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>442x</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>3-26</u> , 19 <u>68</u> , to <u>4-5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Chs J. Grigoleit MD</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/5/68			
22d. PHYSICIAN'S NAME (Type) A.W. GRIGOLEIT				22e. ADDRESS Harro de Grace							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-9-68		23c. NAME OF CEMETERY OR CREMATORY Bay View Cem.			23d. LOCATION (City or Town) (County) (State) Bay View Cecil Md.				
24. FUNERAL DIRECTOR Richard L Goodie				ADDRESS Rising Sun Md		25a. REC'D BY REGISTRAR DATE APR 9 - 1968		25b. REGISTRAR'S SIGNATURE <u>Richard L Goodie</u>			

STATE OF TEXAS
DEPARTMENT OF HEALTH

10100

10100

Blank lined form with horizontal ruling lines.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05702

05705

1. DECEASED-NAME (Type or print) First Middle Last Leo Jack Bonin			2a. DATE OF DEATH Month Day Year April 23 68			2b. HOUR 3:30A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH October 31, 1895		6. AGE (In years lost birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) France		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Chicken Farmer		12b. KIND OF BUSINESS OR INDUSTRY Self Employ			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 274	
14. FATHER'S NAME First Middle Last Peter Bonin			15. MOTHER'S MAIDEN NAME First Middle Last Mary Bonin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 221-09-5770		17. INFORMANT Address Mrs. Leo. J. Bonin Risings Sun, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 y.s.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 331x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-6 , 19 67 , to 4-23 , 19 68 , that (I) (we) last saw the deceased alive on 4-23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Neil R. Taylor DEGREE MB.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-25-68			
22d. PHYSICIAN'S NAME (Type) Neil R. Taylor MB.				22e. ADDRESS Rising Sun, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-1968		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cem.		23d. LOCATION (City or Town) (County) (State) Rising Sun Cecil Md.			
24. FUNERAL DIRECTOR William M. Mullen				ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Annie LEE Castell					2a. DATE OF DEATH Month 4 Day 29 Year 68			2b. HOUR 9 P. M.	
3. SEX F		4. RACE Wh		5. DATE OF BIRTH 1-5-1880		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air, md.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 704 Hickory Ave Bel Air, md.	
14. FATHER'S NAME First Charles Edward Middle Ely Last Ely				15. MOTHER'S MAIDEN NAME First Sarah Middle Elizabeth Last Forwood					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-44-3326		17. INFORMANT (Sister) 838-6830 Mrs. Lulu B. Boyle Address 704 Hickory Avenue Bel Air, Maryland 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerotic Cardio- DUE TO, OR AS A CONSEQUENCE OF (c) Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/29 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4221 Smiling.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 months 2-3 years.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 1st, 1967 , to April 29, 1968 , that (I) (we) last saw the deceased alive on April 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward C. Loo, M.D.				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/29/68	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS Havre de Grace, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co., Md. 21014			
24. FUNERAL DIRECTOR Joseph William Foster				ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR DATE MAY 1 00 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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DEPARTMENT OF STATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ELMER First (NMN) Middle COMBS Last		2a. DATE OF DEATH 4 Month 14 Day 68 Year		2b. HOUR 4:40 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 7/20/15	6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH HARFORD	
10. CITY OR TOWN OF DEATH HAVRE de GRACE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER	12b. KIND OF BUSINESS OR INDUSTRY St. Rd. Comm.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY HARFORD	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RD 2 Box 98-A
14. FATHER'S NAME First Jacob Middle (NMN) Last COMBS	15. MOTHER'S MAIDEN NAME First ROSA Middle — Last CROUSE	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		
16b. SOCIAL SECURITY NO. 238-10-9162		17. INFORMANT (Name, address, and relationship) WIFE 838-5067 Mrs. JEAN B. Combs Address RD #2, Box #98-A Bel Air, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 331X Asthma & Emphysema				
19a. DATE OF OPERATION 4/10/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pyloric stenosis (ulcer)	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> refused	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 4/9/68 , 19__, to 4/14/68 , 19__, that (I) (we) last saw the deceased alive on 4/14/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Carl Grigoleit MD		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/14/68	
22d. PHYSICIAN'S NAME (Type) A.W. GRIGOLEIT		22e. ADDRESS Havre de Grace, Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 17, 1968	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co., Maryland 21014	
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014	25a. RECD BY REGISTRAR DATE APR 17 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

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1. *Abstract*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last Thomas Gordon Coulter										Month Day Year April 21 1968										40 M																													
3. SEX M										4. RACE W										5. DATE OF BIRTH 6-18-93										6. AGE (In years lost birthday) 74 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Hartford Md.																			
10. CITY OR TOWN OF DEATH Haore de Grace										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) R. Engineer (ret'd.)										12b. KIND OF BUSINESS OR INDUSTRY railroad																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Hartford										13c. CITY OR TOWN Hartford										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 2106 Railroad Ave.									
14. FATHER'S NAME First Middle Last Morris M. Coulter										15. MOTHER'S MAIDEN NAME First Middle Last Emma V. Bunce										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 717-07-6079										17. INFORMANT Address Mrs. Florence E. Schumaker, 2106 Railroad Ave. Edgewood, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the liver.</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 163 x tubercles met. 1 ascl. CVD.																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE <u>Lajos Mezei</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED April 21, 1968																													
22d. PHYSICIAN'S NAME (Type) Lajos Mezei, M.D.										22e. ADDRESS Haore de Grace, Maryland																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Apr. 24, 1968										23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial Cemetery										23d. LOCATION (City or Town) (County) (State) Abingdon Hartford Md																			
24. FUNERAL DIRECTOR Howard K. McComas, & Son, Abingdon, Md.										ADDRESS										25a. REC'D BY REGISTRAR APR 24 1968										25b. REGISTRAR'S SIGNATURE Charles J. Jones																			

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THOMAS G. CARVER

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Hartford

U.S.A.

THOMAS G. CARVER, CHAIRMAN, HARTFORD, CONNECTICUT

MR. HARTFORD, CONNECTICUT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

05706										05709									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Charles Grant Dawson					2a. DATE OF DEATH April 13, 1968					2b. HOUR 1:18 M									
3. SEX Male			4. RACE White			5. DATE OF BIRTH April 13, 1903			6. AGE (In years last birthday) 65 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD Md.										
10. CITY OR TOWN OF DEATH HAVRE DE GRACE				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAINTER				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.				13b. COUNTY HARFORD		13c. CITY OR TOWN DARLINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt 1 Box 2									
14. FATHER'S NAME First Middle Last GRANT Dawson					15. MOTHER'S MAIDEN NAME First Middle Last SARAH JANE CARTER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 214-18-9515					17. INFORMANT Address Mrs. C.G. Dawson, Darlington, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436.9 Cardiovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Senescent Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 249ns										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30-40 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from May 12, 1947 , to April 13, 1968 , that (I) (we) lost saw the deceased alive on Apr. 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Dudley Phillips MD DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 4/13/68									
22d. PHYSICIAN'S NAME (Type) Dudley Phillips MD										22e. ADDRESS Darlington MD 21034									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE 4-15-68					23c. NAME OF CEMETERY OR CREMATORY ASCENSION					23d. LOCATION (City or Town) (County) (State) STREET, HARFORD, MD.				
24. FUNERAL DIRECTOR JOHN H. HARKINS, DELTA, PA. ADDRESS										25a. REC'D BY REGISTRAR APR 16 1968					25b. REGISTRAR'S SIGNATURE Charles Judge				

00700

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

00700

MEMORANDUM FOR THE ATTORNEY GENERAL
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]
[The remainder of the memorandum text is illegible due to extreme fading.]

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
WILLIS		FRANK		DINSMOOR				2a. DATE KNOWN OF DEATH		4-21		1968				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day	
Male		White				58 YRS.		MONTHS		DAYS		2c. DATE PRONOUNCED DEAD		4		21	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH				2d. HOUR	
N.Y.		U.S.A.				X						HARFORD				5:15 PM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
HAVRE DE GRACE MD		Harford Memorial Hospital		STOCK CLERK		SHIP YARD											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Md		Harford		Port Deposit		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 42									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
GLENN		DINSMOOR						PEARL AGNES NICKERSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		WORLD WAR II		071-10-5770		MARGARET S. DINSMOOR		PORT DEPOSIT, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt injuries of thorax																	
819.9 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
8254																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
						12:04xx 4-20 19 68						Involved in auto accident					
21d. INJURY OCCURRED						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						Highway						Rt. 222 Perryville at Rte 275 Cecil Harford Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE						Charles S. Springate, M.D.						22b. DATE SIGNED					
EXAMINER'S NAME (Type)						Charles S. Springate, M.D.						April 22, 1968					
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY					
BURIAL						4-24-1968						HOPEWELL CEM.					
24. FUNERAL DIRECTOR						ADDRESS						25a. REC'D REGISTRAR					
R. MADISON MITCHELL						HAYRENE GRACE						APR 24 1968					
25b. REGISTRAR'S SIGNATURE						25c. REGISTRAR'S SIGNATURE											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OFFICIAL RECORDS SECTION OF DEPT. OF JUSTICE

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NOV 1964

DATE	TIME	LOCATION	DESCRIPTION	REMARKS
11/1/64	10:00	Room 101	Meeting with Mr. Smith	Discussed case file # 100-100000
11/2/64	11:00	Room 101	Meeting with Mr. Jones	Discussed case file # 100-100000
11/3/64	12:00	Room 101	Meeting with Mr. Brown	Discussed case file # 100-100000
11/4/64	13:00	Room 101	Meeting with Mr. White	Discussed case file # 100-100000
11/5/64	14:00	Room 101	Meeting with Mr. Black	Discussed case file # 100-100000
11/6/64	15:00	Room 101	Meeting with Mr. Green	Discussed case file # 100-100000
11/7/64	16:00	Room 101	Meeting with Mr. Grey	Discussed case file # 100-100000
11/8/64	17:00	Room 101	Meeting with Mr. Blue	Discussed case file # 100-100000
11/9/64	18:00	Room 101	Meeting with Mr. Yellow	Discussed case file # 100-100000
11/10/64	19:00	Room 101	Meeting with Mr. Purple	Discussed case file # 100-100000
11/11/64	20:00	Room 101	Meeting with Mr. Red	Discussed case file # 100-100000
11/12/64	21:00	Room 101	Meeting with Mr. Orange	Discussed case file # 100-100000
11/13/64	22:00	Room 101	Meeting with Mr. Pink	Discussed case file # 100-100000
11/14/64	23:00	Room 101	Meeting with Mr. Brown	Discussed case file # 100-100000
11/15/64	00:00	Room 101	Meeting with Mr. White	Discussed case file # 100-100000
11/16/64	01:00	Room 101	Meeting with Mr. Black	Discussed case file # 100-100000
11/17/64	02:00	Room 101	Meeting with Mr. Green	Discussed case file # 100-100000
11/18/64	03:00	Room 101	Meeting with Mr. Grey	Discussed case file # 100-100000
11/19/64	04:00	Room 101	Meeting with Mr. Blue	Discussed case file # 100-100000
11/20/64	05:00	Room 101	Meeting with Mr. Yellow	Discussed case file # 100-100000
11/21/64	06:00	Room 101	Meeting with Mr. Purple	Discussed case file # 100-100000
11/22/64	07:00	Room 101	Meeting with Mr. Red	Discussed case file # 100-100000
11/23/64	08:00	Room 101	Meeting with Mr. Orange	Discussed case file # 100-100000
11/24/64	09:00	Room 101	Meeting with Mr. Pink	Discussed case file # 100-100000
11/25/64	10:00	Room 101	Meeting with Mr. Brown	Discussed case file # 100-100000
11/26/64	11:00	Room 101	Meeting with Mr. White	Discussed case file # 100-100000
11/27/64	12:00	Room 101	Meeting with Mr. Black	Discussed case file # 100-100000
11/28/64	13:00	Room 101	Meeting with Mr. Green	Discussed case file # 100-100000
11/29/64	14:00	Room 101	Meeting with Mr. Grey	Discussed case file # 100-100000
11/30/64	15:00	Room 101	Meeting with Mr. Blue	Discussed case file # 100-100000
12/1/64	16:00	Room 101	Meeting with Mr. Yellow	Discussed case file # 100-100000
12/2/64	17:00	Room 101	Meeting with Mr. Purple	Discussed case file # 100-100000
12/3/64	18:00	Room 101	Meeting with Mr. Red	Discussed case file # 100-100000
12/4/64	19:00	Room 101	Meeting with Mr. Orange	Discussed case file # 100-100000
12/5/64	20:00	Room 101	Meeting with Mr. Pink	Discussed case file # 100-100000
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12/10/64	01:00	Room 101	Meeting with Mr. Grey	Discussed case file # 100-100000
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12/25/64	16:00	Room 101	Meeting with Mr. Red	Discussed case file # 100-100000
12/26/64	17:00	Room 101	Meeting with Mr. Orange	Discussed case file # 100-100000
12/27/64	18:00	Room 101	Meeting with Mr. Pink	Discussed case file # 100-100000
12/28/64	19:00	Room 101	Meeting with Mr. Brown	Discussed case file # 100-100000
12/29/64	20:00	Room 101	Meeting with Mr. White	Discussed case file # 100-100000
12/30/64	21:00	Room 101	Meeting with Mr. Black	Discussed case file # 100-100000
12/31/64	22:00	Room 101	Meeting with Mr. Green	Discussed case file # 100-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11)
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Stanley EVANS Dixon			2a. DATE OF DEATH 4 Month 22 Day 68 Year		2b. HOUR 4:35 A. M.
3. SEX male	4. RACE white	5. DATE OF BIRTH 10-31-84		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Harvee de Grace	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizen's Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Milk Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Transport		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Jarrettsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Norrisville Road	
14. FATHER'S NAME First Benjamin Middle Dixon Last		15. MOTHER'S MAIDEN NAME First Emma Middle Chenworth Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) ---	17. INFORMANT Mrs. Hazel D. Malles White Hall, Md. 21161			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days. 1 week. 2-3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4201					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan. 16, 1968 to April 22, 1968 , that (I) (we) last saw the deceased alive on April 22, 1968 and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/22/68	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS Harvee de Grace, Ind.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/24/1968	23c. NAME OF CEMETERY OR CREMATORY Jarrettsville	23d. LOCATION (City or Town) (County) (State) Jarrettsville, Maryland		
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.		25a. REC'D BY REGISTRAR DATE APR 24 1968	25b. REGISTRAR'S SIGNATURE Charles Yunge		

21084

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FOR STATE HEALTH DEPT. 41

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the original. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR	
Lawrence Reid Edwards						Month Day Year			1968 3:05 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	Aug. 28, 1949	18 YRS.	MONTHS DAYS		HOURS MIN.		Month Day Year		1968 3:45 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.	
Harf. Co., Md.		U.S.A.				Harford County,				
10. CITY OR TOWN OF DEATH (DMA)			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace			Harford Memorial Hospital			Student			School	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Harford		Bel Air				39 E. Churchville Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Reid Burnett Edwards			Mildred Virginia Spencer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Father) 838-6063 39 E. Churchville Rd. Bel Air, Md. 21014					
No			215-48-3295							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture skull, open										
DUE TO, OR AS A CONSEQUENCE OF Fracture of Femur										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
8254										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		3:05 AM Apr. 9, 1968		Auto Accident						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				U.S.#1, 1/2 mile north of Bel Air, Harf. Co., Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Gerald C. Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Gerald C. Palmer, M.D. Bel Air, Md. 21014				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		April 9, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		Apr. 11, 1968		Mt. Zion Methodist Cem.		Fountain Green, Harf. Co., Md.				
24. FUNERAL DIRECTOR		W. Broadway & Williams St. Bel Air, Maryland 21014				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph William Foster						APR 11 1968		Charles Judge		

2022 年 1 月 1 日

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First Middle Last				2a. DATE KNOWN OF DEATH		2b. HOUR	
Ethel A. Glasgow						Month Day Year		11 30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
F	W	DEC. 24, 1998	68 YRS.	MONTHS DAYS		HOURS MIN		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
STREET, Md.		U.S.A.		NEVER MARRIED		Hartford			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hartford		DOA Hartford Memorial Hospital				HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md		Hartford		STREET		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		GRIER NURSERY Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
GEORGE AMOS		MARGARET LAIRD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		213-52-6305		CHARLES W. GLASGOW		STREET, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Fracture Skull									
8/19/99 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
8254									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/>		11 PM 4-8-68		Auto Accident					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
		Highway		Street		Hartford		Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED					
Gerald P. Palmer		<input type="checkbox"/>		30/4/98					
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)					
Gerald P. Palmer		<input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		APRIL 11, 1968		EMORY METHODIST		STREET, HARTFORD, MD.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John H. Harding, DELTA, PA.				APR 11 1968		Charles Judge			

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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FOR FILE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>05712</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 5 Film G400 5/2/68 kk</div> <div>CERTIFICATE OF DEATH</div> <div>05714</div>												
1. DECEASED-NAME (Type or print) <u>Clara E. Gumbly</u>						2a. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>68</u>			2b. HOUR <u>5:30</u> PM			
3. SEX <u>Female F</u>		4. RACE <u>C Colored</u>		5. DATE OF BIRTH <u>5/20/1880</u>			6. AGE (In years last birthday) <u>87</u> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Hartford</u> Md.						
10. CITY OR TOWN OF DEATH <u>Harre de Grace</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY _____			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>md</u>				13b. COUNTY <u>Cecil</u>		13c. CITY OR TOWN <u>Port Deposit</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>230 North Main St.</u>		
14. FATHER'S NAME First <u>George</u> Middle <u>W.</u> Last <u>Shortone</u>			15. MOTHER'S MAIDEN NAME First <u>Elizabeth Jane</u> Middle <u>Rice</u> Last _____									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service) _____				16b. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Mae Newman</u>			Address <u>Port Deposit, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD With aneurysm aortic bifurcation with</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>occlusion right renal artery; further compli-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cated by chronic pyelonephritis and uremia</u> <u>451x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diverticulitis of lower colon</u>												
19a. DATE OF OPERATION <u>April 10, 1968</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ at work _____		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) _____				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1968</u> , to <u>April 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>George T. Stansbury, M.D.</u>						DEGREE _____		22c. DATE SIGNED <u>April 16, 1968</u>				
22d. PHYSICIAN'S NAME (Type) <u>George T. Stansbury, M. D.</u>						22e. ADDRESS <u>569 Revolution Street</u> <u>Harre de Grace, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/20/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jones Mem. Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Cecil, Md.</u>				
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son, Perryville, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
James		R.	Hamrick		April Month 7 Day 68 Year		0023 M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
M		Caucasian		5 March 1920		48 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
West Virginia		U.S.A.				Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Aberdeen P.G.		US Kirk Army Hospital		Army Ret		Army					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Harford		Aberdeen		29 w. Belair Ave Box 702					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
James		XXXXXX	XXXXXX	Hamrick	Marie		NMI	XXXXXX	Cunningham		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes		12 FEB 42 - 31 MAR 64		232-05-5303		Katharina Hamrick, 29 W. Belair Ave, Aberdeen					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding Peptic Ulcer DUE TO, OR AS A CONSEQUENCE OF (c) Possible perforation, hepatic cirrhosis CVA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 13 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5401											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 25 March , 19 68 , to 7 April , 19 68 , that (I) (we) last saw the deceased alive on 7 April , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						7 April 1968			
Rogers A. Nosal, M.D.		US Kirk Army Hospital									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Removal		10 Apr. 68		East Oak Grove Cemetery		Morgantown, West Virginia					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Tarring Funeral Home, Aberdeen, Md. 21001				DATE		APR 10 1968					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05712		05716	
1. DECEASED-NAME (Type or print) First <u>Margaret</u> Middle <u>A</u> Last <u>Hendrickson</u>			
2a. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>68</u>		2b. HOUR <u>6:58</u> M	
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>October 25, 1875</u>	6. AGE (in years last birthday) <u>92</u> YRS.
7a. BIRTHPLACE (State or foreign country) <u>Ohio</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH <u>Harford</u>		Md.	
10. CITY OR TOWN OF DEATH <u>Harve de Grace</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Harford Memorial Hosp</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md</u>	13b. COUNTY <u>Harford</u>	13c. CITY OR TOWN <u>Forest Hill</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET AND NUMBER <u>Putnam Road</u>			
14. FATHER'S NAME First <u>John</u> Middle <u></u> Last <u></u>		15. MOTHER'S MAIDEN NAME First <u>Reese</u> Middle <u>Margaret</u> Last <u>Davis</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>215-54-0029</u>	
17. INFORMANT (Sub) <u>838-5823</u> Address <u>Mr. John R. Hendrickson</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D.</u>		?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Senility</u>		?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Acute Pulmonary Edema</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>68</u> , to <u>4/15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Edward C. Loo, M.D.</u>		DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>4/15/68</u>
22d. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22e. ADDRESS <u>211 N. Union Ave, Harve de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 18, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pittsburgh, Alleg. Co., PENNA.</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>APR 18 1968</u>			

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CERTIFICATE OF DEATH

05714

05717

1. DECEASED-NAME (Type or print) Clarence			First	Middle L.	Last Hess	2a. DATE OF DEATH Month April Day 6 Year 68			2b. HOUR 1230 M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 24 March 1909			6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Aberdeen P. G.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Army			12b. KIND OF BUSINESS OR INDUSTRY Army		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD 1, Box 167		
14. FATHER'S NAME Clarence M. Hess			First	Middle	Last	15. MOTHER'S MAIDEN NAME First Geraldine M. Middle Shane Last Gertrude (Not available) XX					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes (If yes give year or dates of service) 1928- May 54			16b. SOCIAL SECURITY NO. 219-36-1499		17. INFORMANT Address Genevieve M. Hess, RFD 1, Box 167, Aberdeen						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Coma DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 5810											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 17 March, 19 68 , to 6 April, 19 68 , that (I) (we) last saw the deceased alive on 6 April, 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Roger A. Nosal						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 6 Apr 68			
22d. PHYSICIAN'S NAME (Type) Roger A. Nosal, M.D.						22e. ADDRESS Kirk Army Hospital, A.P.G., MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11 April 68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Charles Judge			ADDRESS Tarring Funeral Home, Aberdeen, Md. 21001			25a. REC'D BY REGISTRAR DATE APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05718

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <u>Wilton E Holliday</u>		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <u>April 18 1968</u>		2b. HOUR <u>M</u>
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>5/14/1889</u>	6. AGE (In years last birthday) <u>78</u> YRS.	7. IF UNDER 1 YEAR MONTHS <u>1</u> DAYS <u>1</u>
7a. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <u>Harrode Grace</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Harford Memorial Hospital</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Harrode Grace</u>
14. FATHER'S NAME First <u>Benjamin</u> Middle <u>Holliday</u> Last <u>Holliday</u>		15. MOTHER'S MAIDEN NAME First <u>Julia</u> Middle <u>?</u> Last <u>?</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>
17. INFORMANT <u>Harp. Records, Harrode Grace Md.</u>		18. SOCIAL SECURITY NO. <u>Unk</u>		19. ADDRESS <u>Harrode Grace Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture R Femur</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>887X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>9040</u>				
19a. DATE OF OPERATION <u>4/20/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>4-9</u> P.M. <u>1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fell at home</u>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. <u>Havre de Grace</u> City or Town <u>Harford</u> County <u>Md</u> State <u>Md</u>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>De/His. #1</u>		22b. DATE SIGNED <u>4-18-68</u>
EXAMINER'S NAME (Type) <u>Gerald C Palmer - M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/20/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>
24. FUNERAL DIRECTOR <u>Conroy & Son, Harrode Grace Md.</u>		23d. LOCATION (City or Town) <u>Harrode Grace Md.</u> (County) <u>Md</u> (State) <u>Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 22 1968</u>		

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INSTRUMENTS & EQUIPMENT OF BUREAU

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1. The first of the instruments of the Bureau is a...

2. The second of the instruments of the Bureau is a...

3. The third of the instruments of the Bureau is a...

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30. The thirtieth of the instruments of the Bureau is a...

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84. The eighty-fourth of the instruments of the Bureau is a...

85. The eighty-fifth of the instruments of the Bureau is a...

86. The eighty-sixth of the instruments of the Bureau is a...

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88. The eighty-eighth of the instruments of the Bureau is a...

89. The eighty-ninth of the instruments of the Bureau is a...

90. The ninetieth of the instruments of the Bureau is a...

91. The ninety-first of the instruments of the Bureau is a...

92. The ninety-second of the instruments of the Bureau is a...

93. The ninety-third of the instruments of the Bureau is a...

94. The ninety-fourth of the instruments of the Bureau is a...

95. The ninety-fifth of the instruments of the Bureau is a...

96. The ninety-sixth of the instruments of the Bureau is a...

97. The ninety-seventh of the instruments of the Bureau is a...

98. The ninety-eighth of the instruments of the Bureau is a...

99. The ninety-ninth of the instruments of the Bureau is a...

100. The hundredth of the instruments of the Bureau is a...

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05716

05719

1. DECEASED-NAME (Type or print) James Stanley Le Roy Stanley		First James Middle Le Roy Last Stanley		2a. DATE OF DEATH Month April Day 30 Year 1968		2b. HOUR 0910M					
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH APR 30 1968		6. AGE (In years lost birthday) YRS. 5		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 5 MIN. 5	
7a. BIRTHPLACE (State or foreign country) Ma		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford					
10. CITY OR TOWN OF DEATH Aberdeen Prov Gr		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NA		12b. KIND OF BUSINESS OR INDUSTRY NA					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Ma		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER D-8-4 Pritchard, Aberdeen,			
14. FATHER'S NAME First Dennis Middle Huff Last Ginger		15. MOTHER'S MAIDEN NAME First Raney Middle Huff Last Huff									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NA		16b. SOCIAL SECURITY NO. NA		17. INFORMANT Dennis Huff, D-8-4 Pritchard, Aberdeen, M							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress 7762 DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c) Since Birth											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 7735											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Apr 30, 1968 , to Apr 30, 1968 , that (I) (we) last saw the deceased alive on Apr 30, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George R. Stanley		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 30, 1968	
22d. PHYSICIAN'S NAME (Type) GEORGE STANLEY, MAJ, MC		22e. ADDRESS Kirk Army Hospital, APG, Md 21005									
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/2/1968		23c. NAME OF CEMETERY OR CREMATORY Ye Bolt Cemetery		23d. LOCATION (City or Town) (County) (State) Harrett, Oklahoma					
24. FUNERAL DIRECTOR Tarney Funeral Home Aberdeen Maryland		ADDRESS 414 W. W. W. St.		25a. REC'D BY REGISTRAR DATE MAY 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

30M REV.
81-09455

01530

1/2/87 to 1/2/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last INFANT BOY HUFF --B						2a. DATE OF DEATH Month Day Year APRIL 30 1968			2b. HOUR 1210 PM			
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH APRIL 30 1968			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Aberdeen Prov Gr				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NA			12b. KIND OF BUSINESS OR INDUSTRY NA	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8-4, Pritchard, Aberdeen, Md		
14. FATHER'S NAME First Middle Last Dennis Huff						15. MOTHER'S MAIDEN NAME First Middle Last Ginger L Huff						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NA				16b. SOCIAL SECURITY NO. NA		17. INFORMANT Address Dennis Huff, D-8-4 Pritchard, Aberdeen, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Prematurity												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
776 X												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from April 30 1968 , to April 30 1968 , that (I) (we) last saw the deceased alive on April 30 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE George R. Stanley DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 30, 1968				
22d. PHYSICIAN'S NAME (Type) GEORGE STANLEY, MAJ, MC						22e. ADDRESS Kirk Army Hospital, APG, Md 21005						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/2/1968		23c. NAME OF CEMETERY OR CREMATORY St. Bolt Cemetery				23d. LOCATION (City or Town) (County) (State) Harford, Oklahoma				
24. FUNERAL DIRECTOR Tanning Funeral Home - Aberdeen Maryland		25a. REC'D BY REGISTRAR Walter McCann				25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 6 1968				

MEDICAL CERTIFICATION

51520

[Faint handwritten notes at the bottom of the page]

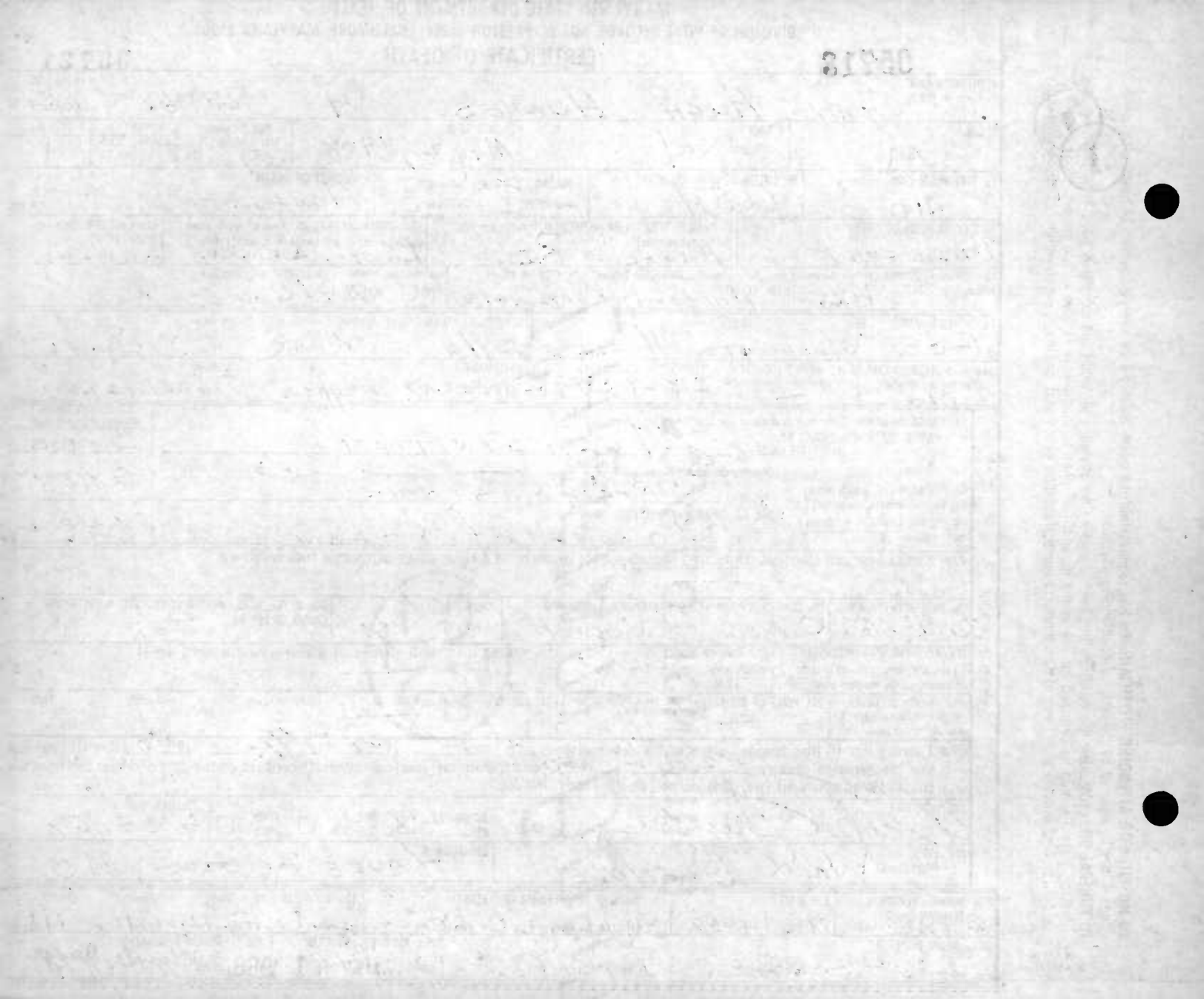
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) JOHN HUGH HUGHES			2a. DATE OF DEATH 4 Month 28 Day 68 Year		2b. HOUR 11:40 A M
3. SEX M	4. RACE W	5. DATE OF BIRTH May 2, 1908		6. AGE (In years lost birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH HARFORD Md.		
10. CITY OR TOWN OF DEATH - DARLINGTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HUGHES RD.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NUMBER DEALER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Harford	13c. CITY OR TOWN DARLINGTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER HUGHES RD
14. FATHER'S NAME First Middle Last GEO. WASHINGTON HUGHES		15. MOTHER'S MAIDEN NAME First Middle Last MAR ELLA SMITH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 218-29-0353		17. INFORMANT Address Katherine Hughes Darlington	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALNUTRITION 1538 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cancer of Colon (c) Cancer of Colon APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos 6 mos 1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1538					
19a. DATE OF OPERATION 23 Mar '67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Mar , 19 67 , to Apr , 19 68 , that (I) (we) last saw the deceased alive on 23 Apr 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wm. K. Brendle DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4-28-68	
22d. PHYSICIAN'S NAME (Type) Wm. K. BRENDLE				22e. ADDRESS HAUCE de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 1, 1968	23c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery		23d. LOCATION (City or Town) (County) (State) Darlington Harford Co., Md.
24. FUNERAL DIRECTOR John H. Harkins		ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR Charles Judge DATE MAY 11 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05719

05722

1. DECEASED-NAME (Type or print) Baby Boy			First Middle Last			2a. DATE OF DEATH Month Day Year Apr. 26 1968			2b. HOUR 5:15 AM		
3. SEX MALE			RACE White			5. DATE OF BIRTH 4-25-68			6. AGE (In years last birthday) - YRS. MONTHS 2 DAYS 2 HOURS 15 MIN.		
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD Md.		
10. CITY OR TOWN OF DEATH HAURE de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY HARFORD			13c. CITY OR TOWN HAURE de Grace			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Rudolph Huss			15. MOTHER'S MAIDEN NAME First Middle Last Margaret L. Waedel			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. ---		
17. INFORMANT Margaret W. Huss, Haure de Grace, Maryland.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA 74771 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COARCTATION OF AORTA + ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) PATENT DUCTUS CONGENITAL			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7546											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 25, 1968 , to April 26, 1968 , that (I) (we) last saw the deceased alive on April 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. Norman			22c. DATE SIGNED 4.26.68			22d. PHYSICIAN'S NAME (Type) R. Norman M.D.			22e. ADDRESS Haure de Grace, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/27/1968			23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery			23d. LOCATION (City or Town) (County) (State) Port Deposit, Maryland.		
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland.			25a. REC'D BY REGISTRAR MAY 2 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <i>Thelma Elizabeth Hutton</i>						2a. DATE OF DEATH Month <i>4</i> Day <i>30</i> Year <i>68</i>			2b. HOUR <i>6 P M</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>SEPT. 16, 1905</i>			6. AGE (In years last birthday) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Penna</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Hartford</i> Md.						
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Pa</i>			13b. COUNTY <i>YORK</i>			13c. CITY OR TOWN <i>Delta</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>MAIN STREET</i>		
14. FATHER'S NAME First Middle Last <i>George Steven Hamilton</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Mabel McAllister</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown (If yes give war or dates of service) <i>No</i>				16b. SOCIAL SECURITY NO. <i>162-22-7745</i>		17. INFORMANT <i>PAUL F. HUTTON, DELTA, PA.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infectious + Urinary Obstruction</i> <i>183.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma Ovary</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1750</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Irvin L. Waxman M.D.</i>						22c. DATE SIGNED <i>4/30/68</i>						
22d. PHYSICIAN'S NAME (Type) <i>IRVIN L. WAXSMAN M.D.</i>						22e. ADDRESS <i>HAVRE DE GRACE, MD.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5-3-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SLATEVILLE</i>		23d. LOCATION (City or Town) (County) (State) <i>DELTA, YORK, PA.</i>						
24. FUNERAL DIRECTOR <i>JOHN H. HARKINS</i>				ADDRESS <i>DELTA, PA.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05721		05724	
1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Pylesville		c. LENGTH OF STAY IN 1b 41 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Pylesville		d. STREET ADDRESS Quarry Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Quarry Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BESSIE Middle FRANCES Last JONES		4. DATE OF DEATH Month April Day 10 Year 1968	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 16, 1892
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Delta, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Bulette		14. MOTHER'S MAIDEN NAME Carrie Singleton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-5044	
17. INFORMANT William A. Jones, Pylesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Cardiac Failure DUE TO (b) Arteriosclerotic CVD disease DUE TO (c) lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4221			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 9, 1967 , to April 10, 1968 , that (I) (we) last saw the deceased alive on April 9, 1968 , and that death occurred at Delta, Penn. M, from causes and on the date stated above.			
22a. SIGNATURE Jonah A Hunt		22b. DATE SIGNED 4/12/68	
22c. PHYSICIAN'S NAME (Type) Loisiah A Hunt MD		22d. ADDRESS Delta, Penn.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 13, 1968	23c. NAME OF CEMETERY OR CREMATORY Slate Ridge Cemetery	23d. LOCATION (City or Town) (County) (State) Delta, York Co., Pa.
24. FUNERAL DIRECTOR John H. Harkins		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Delta, Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE APR 16 1968			

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05722

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05725

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
Emory				C.	Jones	Month 4 Day 24 Year 1968			6:50 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
male		white		09-10-89			78 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland		USA					Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Hayre de Grace, MD.			Citizens Nursing Home			Carpenter						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Harford		Joppatowme				803 Chatfield Road			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
David					Jones	Annie					Lockner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
Unknown			218-05-1315			Mrs. Merry M. Brown			803 Chatfield Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Cardiac Decompensation										2 days		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause										2-3 years		
(b) A.S. C.V.D.												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
Diabetes mellitus + Emphysema												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/13, 1968, to 4/24, 1968, that (I) (we) last saw the deceased alive on 4/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Edward C. Loo, M.D.										4/24/68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
Edward C. Loo, M.D.						Hayre de Grace, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Apr 27, 1968			Meadowridge			Howard Co. Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Donovan			APR 26 1968			Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (M)
30M REV. 1/68

05722

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05726

1. DECEASED-NAME (Type or print) First Middle Last <u>Albert J. Lacoste</u>			2a. DATE OF DEATH Month Day Year <u>4 5 1968</u>			2b. HOUR M <u></u>						
3. SEX <u>Male</u>		4. RACE <u>Cau.</u>		5. DATE OF BIRTH <u>8-30-1909</u>		6. AGE (In years last birthday) <u>58</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS <u></u>		IF UNDER 24 HRS. HOURS MIN. <u></u>		
7a. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Harford</u> Md.						
10. CITY OR TOWN OF DEATH <u>Fallston</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Rosehill Farm Rd.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Trainer of Horses</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Selfempl</u>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>W. Va.</u>		13b. COUNTY <u></u>		13c. CITY OR TOWN <u>Charlestown</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u></u>				
14. FATHER'S NAME First Middle Last <u>Peare J. Lacoste</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Ernestine Roudel</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <u>No</u>			16b. SOCIAL SECURITY NO. <u>136-05-9310</u>		17. INFORMANT <u>Box 37</u> Address <u>Cornellia M. Lacoste Rose Hill Falston 21047</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESP FAILURE</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CARCINOMA OF BRAIN</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF LUNG</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>6 MO</u> <u>2 YRS</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>163X</u>												
19a. DATE OF OPERATION <u></u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <u></u> P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u></u>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u></u>			21f. LOCATION Street or R.F.D. No. City or Town County State <u></u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>1 FEB 1968</u> , to <u>4 APR 1968</u> , that (I) (we) last saw the deceased alive on <u>MAR 25 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>H. P. Sidwell MD</u>					DEGREE <u></u>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5 APR 68</u>	
22d. PHYSICIAN'S NAME (Type) <u>H. P. SIDWELL MD</u>					22e. ADDRESS <u>401 FRANKLIN ST BELAIR MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-8-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford Md.</u>					
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7461 Belair Road</u>					ADDRESS <u>21236</u>		25a. REC'D BY REGISTRAR <u>APR 8 - 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

03730

STATEMENT OF DEATH

03730

2000
2 MO
2002

CAUSE OF DEATH
HEART DISEASE
CHOCOLATE OF LUNG

13 MAY 2002

H. P. SLOWELL MD
J. H. SLOWELL MD

FOOTNOTES AT BOTTOM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115/48
30M REV. 11/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05724		05727									
1. DECEASED-NAME (Type or print) First Middle Last George Bernard Meyer			2a. DATE OF DEATH Month Day Year April 14 1968		2b. HOUR 10 P M						
3. SEX male		4. RACE white		5. DATE OF BIRTH July 22, 1905		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) CONN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARford.					
10. CITY OR TOWN OF DEATH Havre de Grace, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) veterinarian		12b. KIND OF BUSINESS OR INDUSTRY self-employed					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2305 Rosewood Drive, Edgewood, Md.			
14. FATHER'S NAME First Middle Last George Meyer			15. MOTHER'S MAIDEN NAME First Middle Last Anna Bakalar								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 007-38-7462		17. INFORMANT Address Howard G. Meyer, R.R. 1, Box 328, Abingdon, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2509 Acute myocardial inf. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 260X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lajof Mezei				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 14, 1968			
22d. PHYSICIAN'S NAME (Type) Lajof Mezei				22e. ADDRESS Havre de Grace, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE April 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Joppa Harford Md					
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

45730

0201 1 1 894

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
LAWRENCE IRA MITCHELL					April 18 1968		12:20		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
MALE	white		22 Nov. 1916		51				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	U.S.A.				HARFORD Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
HAVER de Grace		HARFORD Memorial Hosp		Merchant		General Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		HARFORD		Churchville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD #1 Box 53	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
Seymour R. Mitchell		Kate Ritter (D)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		212-16-9076		Nancy Mitchell, Churchville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extensive anterior myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary thrombosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>5 hrs.</u> <u>5 hrs.</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> , 19 <u>68</u> , to <u>4/18</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Edward C. Loo, M.D.</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/18/68</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Edw. C. Loo, M.D.		Haver de Grace, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		20 Apr. 68		St Marys Episcopal Cemetery		Bel Air, Maryland			
24. FUNERAL DIRECTOR <u>Walter Macomber Jr.</u>		Tarring Funeral Home Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE <u>APR 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2550

W3.13700

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05726

05729

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month Day Year		2b. HOUR	
Gordon		Bruce		Moore				April, 13 1968				2:50	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	White	May 19, 1951		16 YRS.						April Day 13 Year 19 68		2:50	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Md.		USA				Harford						Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Havre de Grace, Md.		Harford Memorial Hospital, DOA		Student									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Md.		Harford		Edgewood				318 Crestwood Drive,					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
Gordon		E.		Moore				Yvonne		--		Siler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS						Md	
no		215-58-1452		Norman C. Moore, 42 Mitchell Ave., Aberdeen									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Cervicle Vertebrae</u> 819.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8254													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 2:35 PM 4-13 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto Accident					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State Willoughby Beach Road, Edgewood, Harford, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>				22b. DATE SIGNED 4-13-68					
EXAMINER'S NAME (Type) <u>Gerald C. Palmer, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		April 16, 1968		Harford Memorial Gardens		Aldino Harford Md							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard K. McComas & Son, Abingdon, Md.								DATE APR 16 1968		<u>J. Charles Judge</u>			

POSTED

RECEIVED

1953

RECEIVED

1

1953

1953

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <i>Nettie Lee Moore</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 4-1 1968			2b. HOUR 11:35 AM			
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>6/22/1885</i>	6. AGE (In years last birthday) <i>82 YRS.</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>April</i> Day <i>1</i> Year <i>1968</i>		2d. HOUR <i>11:35 AM</i>	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i>			
10. CITY OR TOWN OF DEATH <i>Harford</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Rel. Companion</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Rising Sun</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Cherry St.</i>	
14. FATHER'S NAME First <i>George</i> Middle <i>Powell</i> Last <i>-</i>			15. MOTHER'S MAIDEN NAME First <i>Netta</i> Middle <i>Edwards</i> Last <i>-</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>224-32-7228</i>		17. INFORMANT <i>Mrs. Chas. T. Crothers</i>			ADDRESS <i>Rising Sun, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Femur</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>904.7</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year - HOUR A.M. P.M. <i>3-20 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <i>Nursing Home</i>		21f. LOCATION Street or R.F.D. No. City or Town County State <i>Havre de Grace Harford Md.</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>4-1-68</i>			
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Morris Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Deltaville Middlesex Va.</i>			
24. FUNERAL DIRECTOR <i>Richard L. Goodie</i>				ADDRESS <i>Rising Sun, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 3 - 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

WATER

MINISTRY OF AGRICULTURE

0533



CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Vivian M. NORTON</i>			2a. DATE OF DEATH Month <i>4</i> Day <i>7</i> Year <i>68</i>			2b. HOUR M			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>7 FEB 24, 1897</i>		6. AGE (In years lost birthday) <i>71</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Vermont</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.			
10. CITY OR TOWN OF DEATH <i>Harre-de-Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>UNK</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>UNK</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Forest Hill</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>RD Box 635 SHARON ROAD</i>	
14. FATHER'S NAME First <i>Chester</i> Middle <i>Guyett</i> Last <i>Norton</i>			15. MOTHER'S MAIDEN NAME First <i>INEZ</i> Middle <i>Norton</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>UNK</i>		(If yes give war or dates of service) <i>UNK</i>		16b. SOCIAL SECURITY NO. <i>UNK</i>		17. INFORMANT Address <i>HARFORD MEMORIAL HOSP. RECORDS</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary failure</i> <i>492.1</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Emphysema & pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>522.1</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>4-7, 1968</i> , to <i>4-7, 1968</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>H. Chung for Leyte</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Apr 8, 68</i>			
22d. PHYSICIAN'S NAME (Type) <i>H. CHUNG FOR LEYTE</i>				22e. ADDRESS <i>HARFORD MEMORIAL HOSPITAL</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>4/7/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WOODLAND Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>KEENE CHESHIRE N.H.</i>			
24. FUNERAL DIRECTOR <i>Cunningham & Son Harre-de-Grace Md</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>APR 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>William As Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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John Doe

John Doe

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) CORA M. PENNINGTON						2a. DATE OF DEATH Month 4 Day 15 Year 68			2b. HOUR 1:00 P.M.		
3. SEX FEMALE		4. RACE white		5. DATE OF BIRTH 2-15-1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Lacks, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford			Md.		
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizen's Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 684 Star Rt.			
14. FATHER'S NAME First Middle Last Elisha Warner Iley				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Norris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 168-14-1861		17. INFORMANT Margaret P. Jones Forest Hill, Md.		Address Star Rt. Box 684					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 436.9 DUE TO, OR AS A CONSEQUENCE OF (b) PT cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Fract spine, Multiple rib fracture								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks 6 wks 3 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 331X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. Jan 25 1967		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell down basement steps at home; sustained injuries to right chest							
21d. PLACE OF INJURY While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) at home		21f. LOCATION Street or R.F.D. No. City or Town County State Forest Hill Harford Md							
22a. I certify that (I) (this hospital) attended the deceased from 2/17 , 19 68 , to 4/15 , 19 68 , that (I) (we) last saw the deceased alive on 4/14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. H. Sadowsky				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/16/68			
22d. PHYSICIAN'S NAME (Type) W. H. Sadowsky				22e. ADDRESS Havre de Grace, Md. 21078							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/17/1968		23c. NAME OF CEMETERY OR CREMATORY William Watters Mem.		23d. LOCATION (City or Town) (County) (State) Cooptown, Harford, Md.					
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE 100 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street				c. LENGTH OF STAY IN 1b 13 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Horeb Road					d. STREET ADDRESS Mt. Horeb Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sallie Middle Denton Last Ragan			4. DATE OF DEATH Month April Day 4 Year 1968						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/3/1873		9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Grange City, Kentucky			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME O. B. Denton					14. MOTHER'S MAIDEN NAME Leah Newman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-50-4065		17. INFORMANT Mrs. Mildred R. Phillips			Address RD 1 Box 167 Street, Md. 21154	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 4369 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 15 years								INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x Osteoarthritis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 12, 1967 , to Apr. 4, 1968 , that (I) (we) last saw the deceased alive on Apr. 3, 1968 , and that death occurred at 3 A.M. , from the causes and on the date stated above.									
22a. SIGNATURE Robert Barthel					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Apr. 4/68		
22c. PHYSICIAN'S NAME (Type) Robert Barthel					22d. ADDRESS Box #4, Forest Hill, Md. 21050				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/9/1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Park			23d. LOCATION (City, town or county) (State) Lexington, Kentucky	
24. FUNERAL DIRECTOR Charles E. Kurtz					ADDRESS Jarrettsville, Md.		25a. REC'D BY REGISTRAR APR 5 - 1968		
							25b. REGISTRAR'S SIGNATURE Charles Judge		

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VR 415 (11)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			20. DATE OF DEATH			2b. HOUR
Mary Elizabeth Schafer						April 23, 1968			7A. M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Female		White		October 30, 1903		84 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore, Md.		U.S.A.				Harford County, Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bel Air			505 Maitland Avenue			Housewife			Homemaker
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Harford		Bel Air		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		505 Maitland Avenue
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
John C. Wiker			Edna Louise Moore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Husband) 838-7321		Address		
No			215-32-1602		Mr. Peter J. Schafer		505 Maitland Ave. Bel Air, Md. 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CVD Disease</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 443x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 6-17, 1932, to 7-23, 1968, that (I) (we) last saw the deceased alive on 7-22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gerald C. Palmer					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 23, 1968		
22d. PHYSICIAN'S NAME (Type) Gerald C. Palmer, M.D.					22e. ADDRESS S. Main St., Bel Air, Md. 21014				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Apr. 25, 1968		St. John's Episcopal Ch. Cem.		Kingsville, Balto. Co., Md.			
24. FUNERAL DIRECTOR Joseph William Foster		W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR APR 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR		
CHARLES E TORRENCE					APRIL Month 18 Day 1968 Year		4:00 PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE	CAU		12 May 1918		19 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA				Harford Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Aberdeen Prov Gr		Kirk Army Hospital		Soldier		U.S. Army			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md		Harford		Aberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		33 Baker St	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Charles E. Torrence Sr (D)					Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes <input checked="" type="checkbox"/> WW-II		115-07-1779		Helen Torrence		33 Baker St Aberdeen Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of tail of pancreas</u> 157.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 157 X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from April 18, 1968, to April 18, 1968, that (I) (we) last saw the deceased alive on April 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Lawrence W Koch</i>				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 18 1968	
22d. PHYSICIAN'S NAME (Type) LAWRENCE KOCH, CPT, MC				22e. ADDRESS Kirk Army Hospital, APG, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		20 Apr. 68		Harford Memorial Gardens		Aberdeen, (Harford) Maryland			
24. FUNERAL DIRECTOR <i>Walter Wacomb Sr.</i>				ADDRESS Tarring Funeral Home Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE APR 22 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05736 CERTIFICATE OF DEATH 05736										
1. DECEASED-NAME (Type or print) LEE R WILLIAMSON			2a. DATE OF DEATH Month APRIL Day 18 Year 1968			2b. HOUR 3:00				
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH 11 FEB 1917		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Worthville, NC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford				
10. CITY OR TOWN OF DEATH Aberdeen Prov Gr		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SOLDIER		12b. KIND OF BUSINESS OR INDUSTRY US Army				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9 OAK Street		
14. FATHER'S NAME First Middle Last William O. Williamson			15. MOTHER'S MAIDEN NAME First Middle Last Ida Freeman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes (no or unknown)) Yes			16b. SOCIAL SECURITY NO. 1938-1968 242-035435		17. INFORMANT Address Army Personnel Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, massive unexplained 514X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 522X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from April 18, 1968 to April 18, 1968 , that (I) (we) saw the deceased alive on April 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lawrence A. Koch MD					DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 18, 1968	
22d. PHYSICIAN'S NAME (Type) LAWRENCE KOCH, CPT, MC					22e. ADDRESS Kirk Army Hospital, APG, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/23/68		23c. NAME OF CEMETERY OR CREMATORY Post Cemetery		23d. LOCATION (City or Town) (County) (State) Aberdeen Prov. Gr. Harford Md.				
24. FUNERAL DIRECTOR Lee J. Patterson & Sons, Perryman, Md.					25a. REC'D BY REGISTRAR DATE APR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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• *Journal of the American Medical Association*, 1997; 277: 1001-1005

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05737

1. DECEASED NAME (Type or print) ROBERT R. YOUNG				2a. DATE OF DEATH Month APR. Day 20 Year 1968		2b. HOUR 2 P. M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JAN. 26, 1874		6. AGE (In years lost birthday) 94 YRS.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARTFORD Md.	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BREVIN NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY RETIRED	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY CECIL		13c. CITY OR TOWN PERRY POINT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First JOHN Middle HENRY Last YOUNG		15. MOTHER'S MAIDEN NAME First HENRIETTA Middle COFFMAN Last RODNEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/> (If yes give war or dates of service) 476-40-7327-A			
16b. SOCIAL SECURITY NO. 476-40-7327-A				17. INFORMANT Mrs. Arline LAWSON, HAVRE DE GRACE MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of rectum 1541 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 154X Anemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. _____ Month _____ Day _____ Year 19 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1966 , to April 19, 1968 , that (I) (we) last saw the deceased alive on 4/20 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John P. Young				DEGREE <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/20/68	
22d. PHYSICIAN'S NAME (Type) JOHN P. YOUNG				22e. ADDRESS Havre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APR. 25, 1968		23c. NAME OF CEMETERY OR CREMATORY EPPING CEM.		23d. LOCATION (City or Town) (County) (State) EPPING, WILLIAMS CO, NO. DAK.	
24. FUNERAL DIRECTOR R. Madison Nichols, Havre de Grace, Md.				25a. REC'D BY REGISTRAR APR 23 1968		25b. REGISTRAR'S SIGNATURE James J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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